



Michigan Community of Practice for Supporting Families
*Using the Charting the LifeCourse Framework to Improve
Person-Centered Planning in Michigan*

CMH Board Association
Conference
October 2021



Today's Learning Objectives

- **Identify the Charting the LifeCourse core principles and values that are important as we begin to think differently about what it means to support individuals with disabilities to have good lives.**
- **Hear from the Pilot Design Team members on shifting towards utilizing the framework & lessons learned.**
- **Hear from the Design Team Facilitator on the initial findings and key takeaways from the pilot design.**
- **Learn about the Community of Practice next steps and how to get involved**



Setting the Stage: the CoP and CtLC

Michigan's imitative led by Michigan
Developmental Disabilities Council



Communities of practice
are groups of people who
share a passion for
something that they know
how to do and who
interact regularly to learn
how to do it better.

*Blue Space.....intentional space to
create innovation that is safe amongst
chaos and destruction*

(adapted from Creating Blue Space, Hanns Meissner)

**What is a
Community
of Practice?**

*“organized
blue space”*





SUPPORTING FAMILIES

of individuals with intellectual & developmental disabilities

THE NATIONAL COMMUNITY OF PRACTICE • FUNDED BY THE ADMINISTRATION ON INTELLECTUAL & DEVELOPMENTAL DISABILITIES

Goal of National CoP

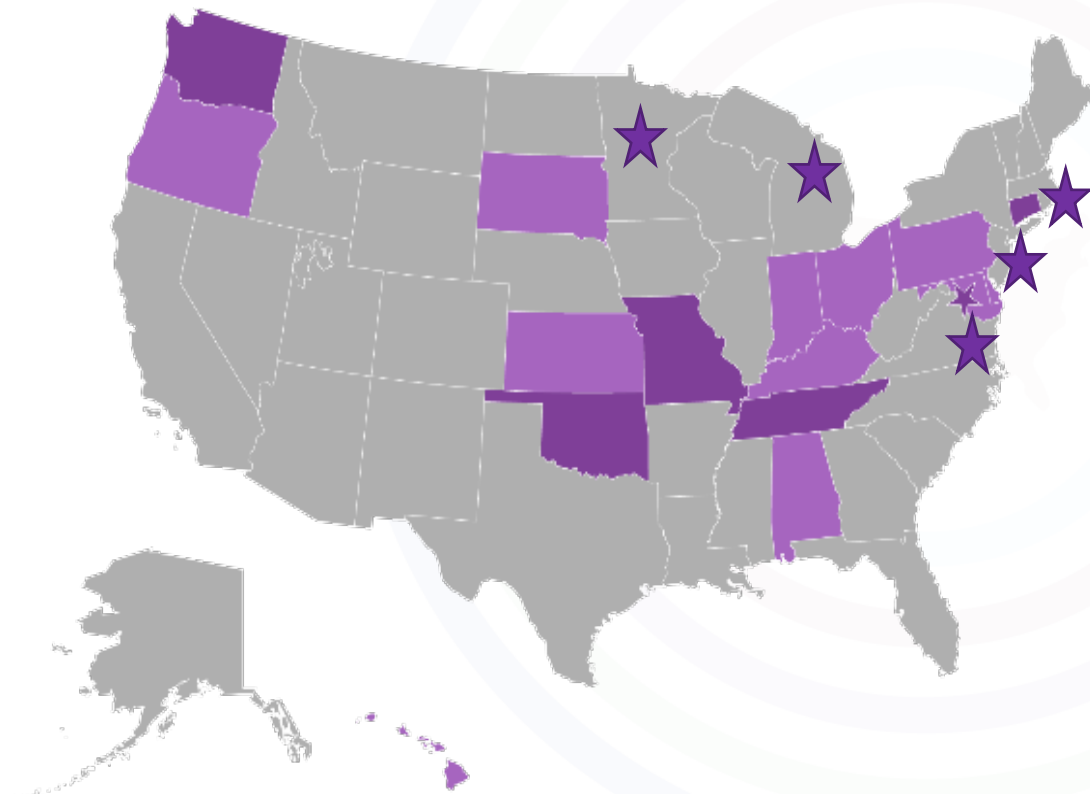
To build capacity, *through a community of practice*,
across and within States

to create policies, practices and systems

to better assist and support families that include a member
with an intellectual and developmental disability
across the lifespan.



National CoP State Members



Development

Maine
Massachusetts
Michigan
Minnesota
New Hampshire
New Jersey
Virginia

Integration

Alabama
South Dakota

Sustainability

Connecticut
DC
Delaware
Hawaii
Indiana
Kansas
Maryland
Missouri
Ohio
Oklahoma
Oregon
Pennsylvania

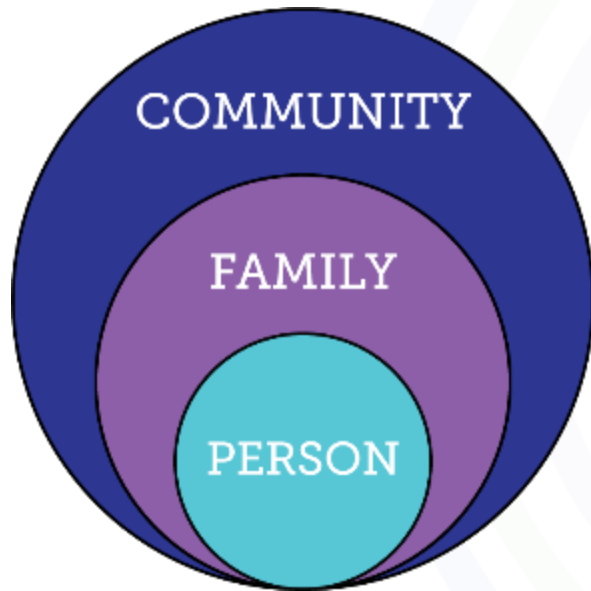




The CoP is about systems changes and infusing the principles into practical, “can do” actions to further state change priorities rather than a new initiative. The added benefit of the skills and values base of the CtLC Framework lends a solid foundation to the systems change work.



Services and Supports are Evolving



Everyone exists
within the context
of family
and community



Traditional
Disability Services



Integrated Services
and Supports within
context of person,
family and community



Joining Forces for a New Vision

1950s Mom-----Parent-----Family Movement

1970s Self-Advocacy and Independent Living
Movements (Nothing about me, without me!)

2000s Siblings Movement

1960s Medicaid and Medicare Established

1980s Medicaid Waiver (Community Supports)

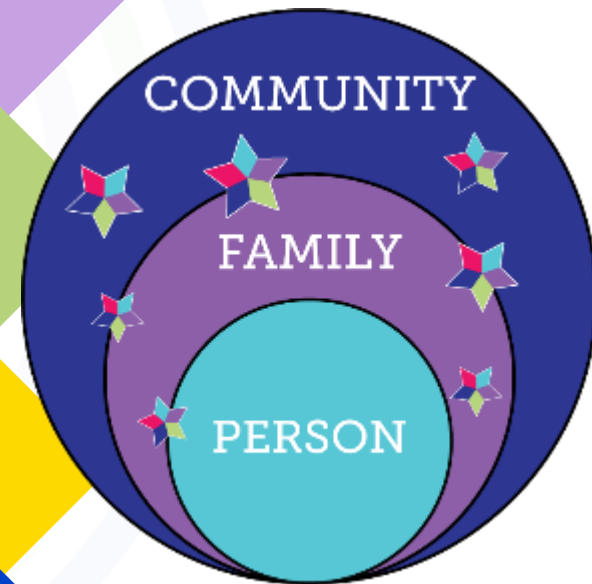
2010s Affordable Care Act

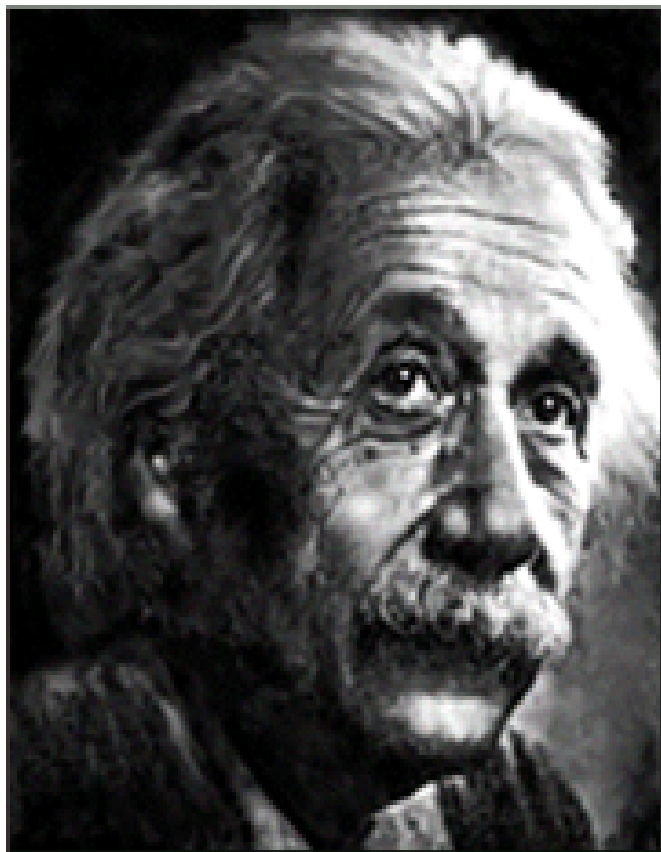
1970s Rehab Act: 504 Plans

1975s Education for All Children

1990s IDEA and ADA

2000's Community and Society





*The significant problems
we face can not be solved
at the same level of
thinking we were at when
we created them.*

Albert Einstein



Type of Change that is Needed

Transitional Change

- ⊙ “Retooling” the system and its practices to fit the new model
- ⊙ Mergers, consolidations, reorganizations, revising systematic payment structures,
- ⊙ Creating new services, processes, systems and products to replace the traditional one

Transformational Change

- ⊙ Fundamental reordering of thinking, beliefs, culture, relationships, and behavior
- ⊙ Turns assumptions inside out and disrupts familiar rituals and structures
- ⊙ Rejects command and control relationships in favor of co-creative partnerships

Creating Blue Space, Hanns Meissner, 2013



What is Charting the LifeCourse

Created to help individuals and families of all abilities and all ages

- *develop a vision for a good life*
- *think about what they need to know and do*
- *identify how to find or develop supports*
- *discover what it takes to live the lives they want to live.*





Core Belief

All people and their families have the right to live, love, learn, work, play and pursue their life aspirations in their community.

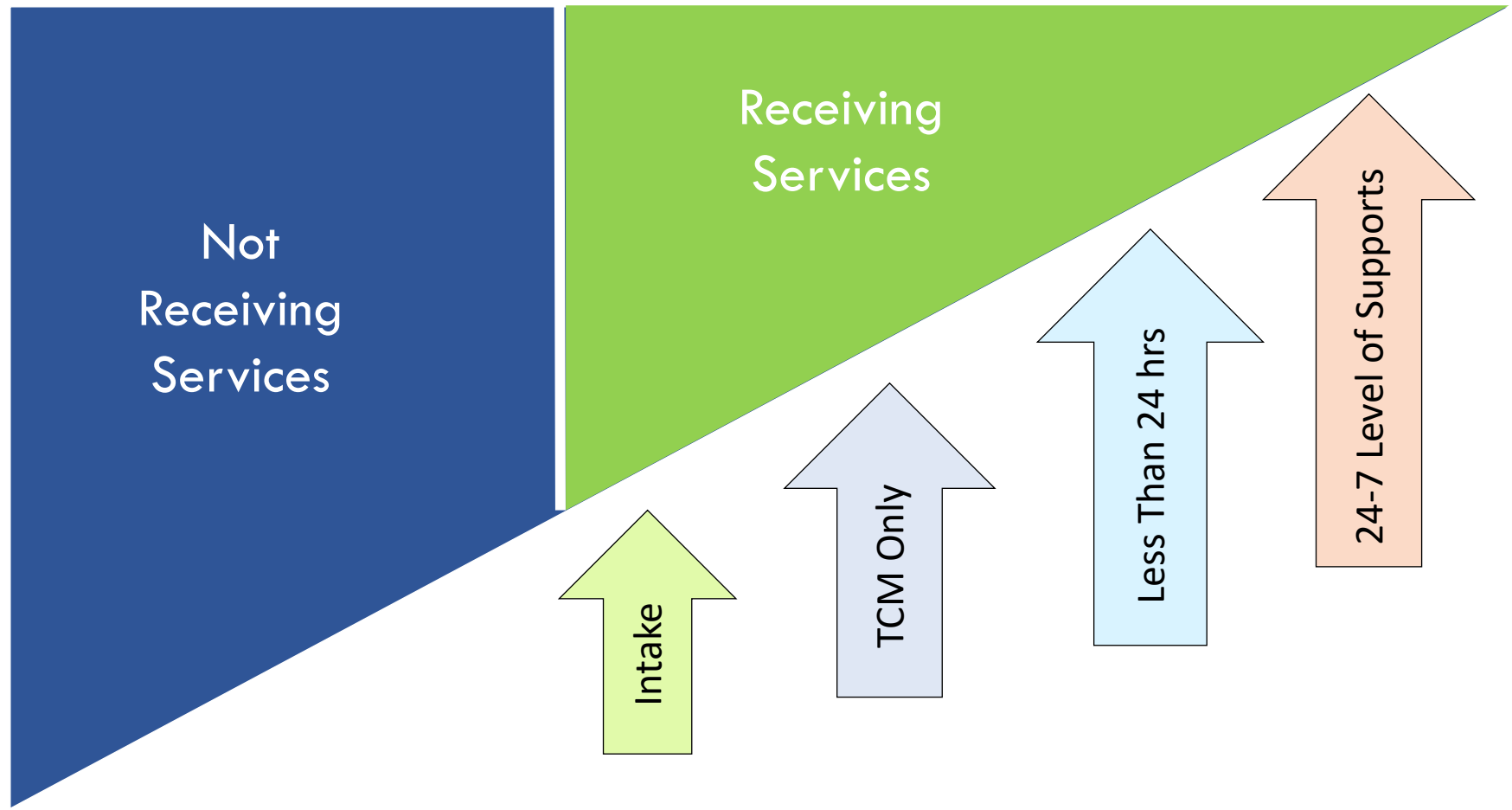


Focusing on the All

All people, regardless of age, ability or family role, are considered in our vision, values, policies and practices for supporting individuals and families. All families have choices and should have access to the supports they need.



Enhancing Practices: Support Coordination







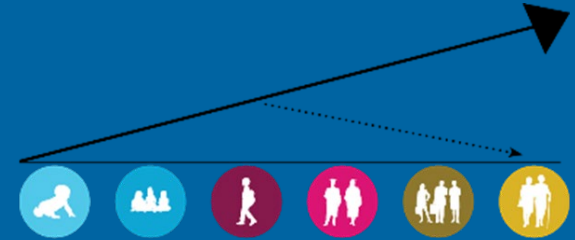
Person in the Context of Family

People exist and have reciprocal roles within a family system, defined by that individual. Roles adjust as the individual members of the family system change and age. The entire family, individually and as a whole, needs support to ensure they all are able to successfully live their good life.



Family Functions and Roles

 Caring About	Share Love, Affection and Trust
	Spend Time and Create Memories Together
	Know About Personal Interests, Traditions, and Cultures
 Caring For	Supports Day-to-Day Needs
	Ensures Material and Financial Needs are Met
	Connects to Meaningful Relationships and Roles
	Advocates and Supports Life Decisions

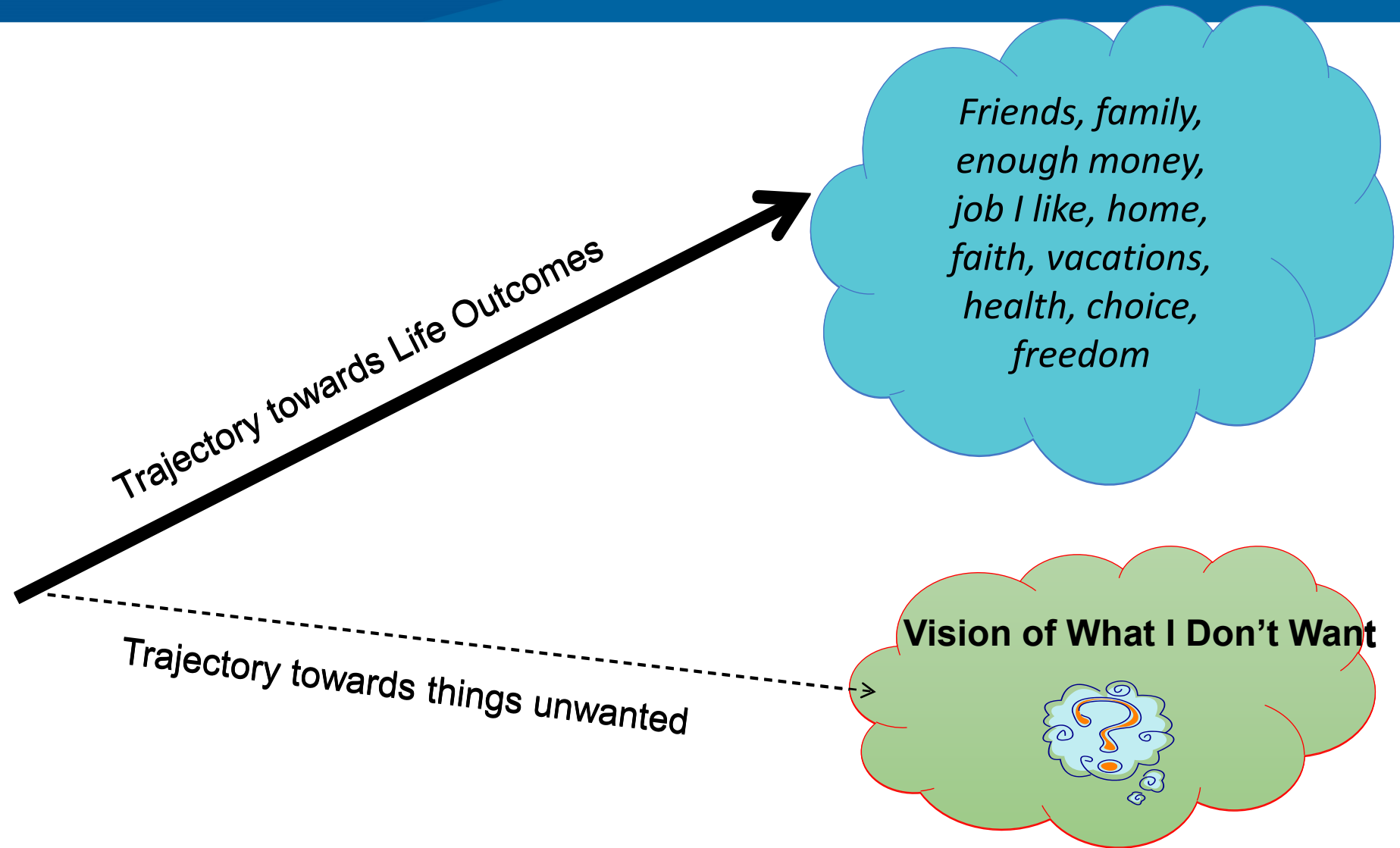


Trajectory and Life Experiences

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Trajectory Towards a Good Life





Holistic Focus across All Life Domains

People lead whole lives made up of specific, connected, and integrated life domains that are important to a good quality of life. Life domains are the different aspects and experiences of life that we all consider as we age and grow.



Focusing on Life Domains



Daily Life and Employment
(school/education, employment, volunteering, routines, life skills)



Healthy Living
(medical, behavioral, nutrition, wellness, affordable care)



Community Living
(housing, living options, home adaptations and modifications, community access, transportation)









Safety and Security
(emergencies, well-being, legal rights & issues, guardianship options & alternatives)



Social and Spirituality
(friends, relationships, leisure activities, personal networks, faith community)



Citizenship and Advocacy
(valued roles, making choices, setting goals, responsibility, leadership, peer support)

LifeCourse Domains	Social Determinants of Health Domains (Healthy People 2020)	
	Education: <ul style="list-style-type: none"> • High School Graduation • Enrollment in Higher Education • Language & Literacy • Early Childhood Education & Development 	Economic Stability: <ul style="list-style-type: none"> • Poverty • Employment • Food Security • Housing Stability
	Neighborhood & Built Environment: <ul style="list-style-type: none"> • Quality of Housing • Environmental Conditions • Access to Healthy Foods 	
	Neighborhood & Built Environment: <ul style="list-style-type: none"> • Crime & Violence • Social & Community Context • Discrimination 	
	Health & Health Care <ul style="list-style-type: none"> • Access to Health Care • Access to Primary Care • Health Literacy 	Economic Stability: <ul style="list-style-type: none"> • Food Security Neighborhood & Built Environment: <ul style="list-style-type: none"> • Access to Healthy Foods
	Social & Community Context <ul style="list-style-type: none"> • Social Cohesion • Incarceration 	
	Social & Community Context <ul style="list-style-type: none"> • Civic Participation 	

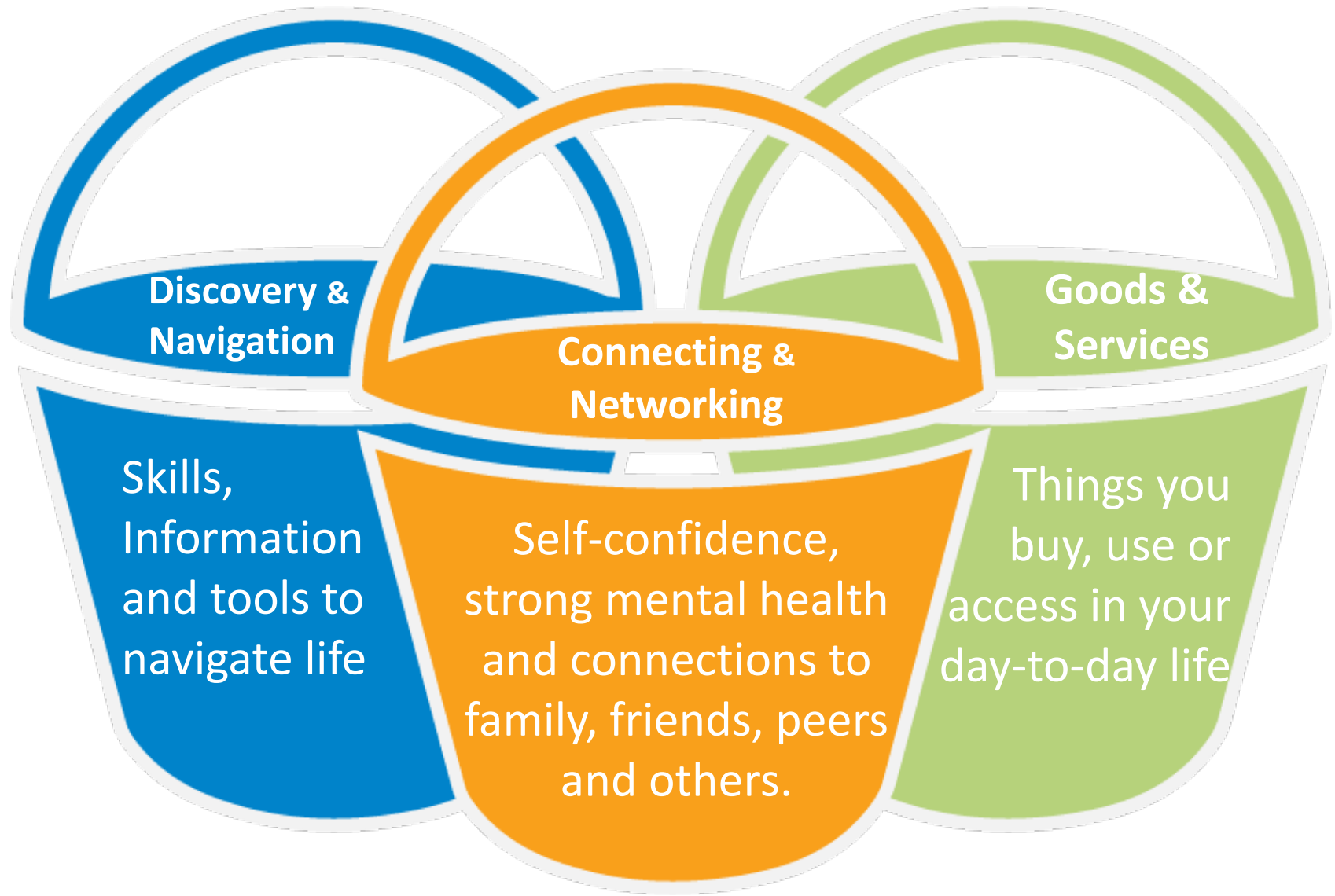


Individualized Supports and Services

Individual and family supports address all facets of life and adjust as roles and needs of all family members change.



Supporting Persons Three Buckets of Needs





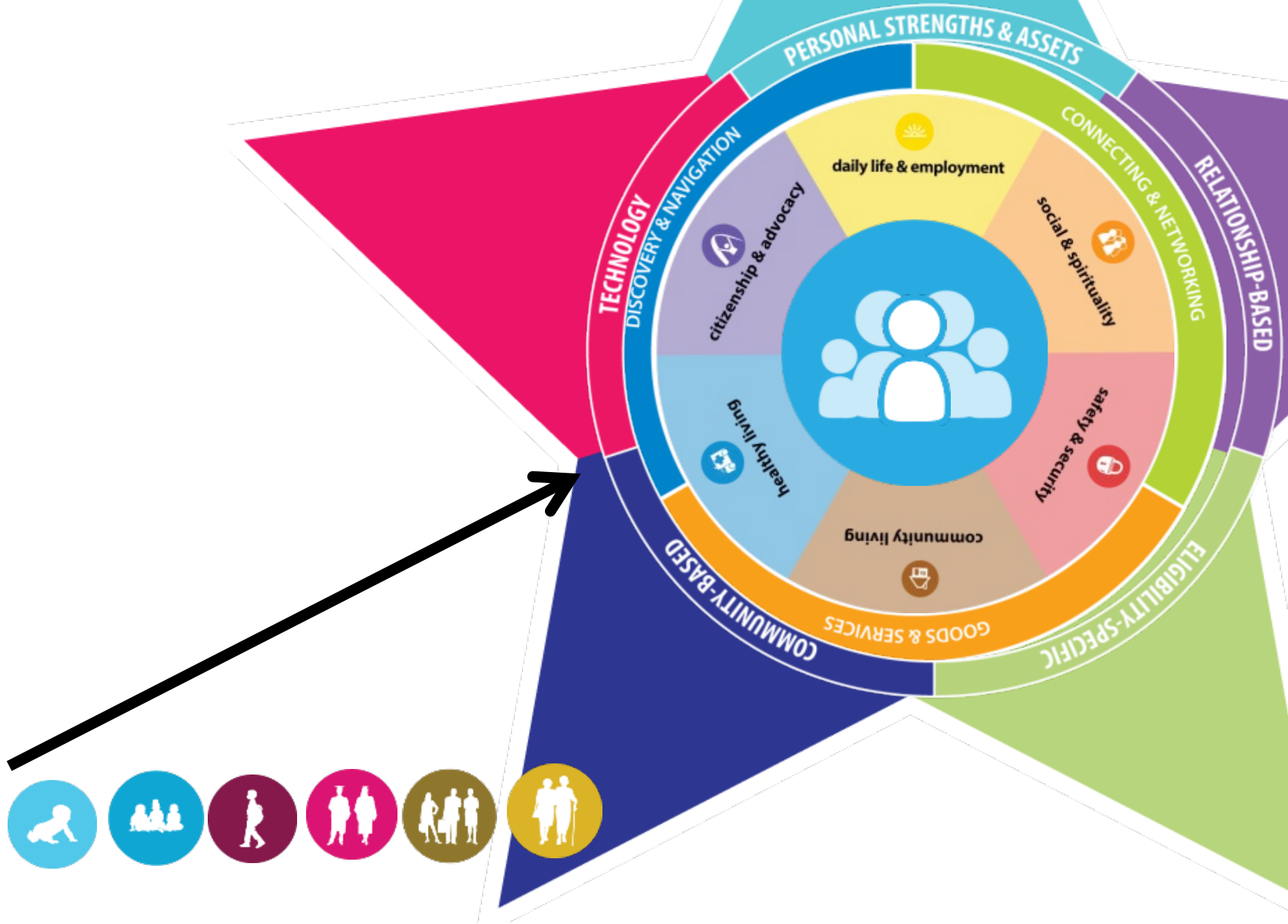
Integrated Supports and Services

Individuals and families access an array of integrated supports to achieve their envisioned good life.



LifeCourse Integrated Supports STAR





Strategies and Tools for Implementing LifeCourse into Practice



Person
Centered
Tools



Family
Perspective
Tools



Planning Tools
for
Professionals

LifeCourse Foundational Tools



Identifying Practices and Designing a Pilot



Pilot Design Team Process Overview

- ◎ Pilot Design Purpose
- ◎ Design Team Roles & Expectations
 - Implement LifeCourse framework and tools in day-to-day work
 - Participate in monthly coaching calls
 - Share feedback
 - Track time and tasks



Three Pilot Sites

- CLS – Oakland and Wayne County – Annette Downey
- Integrated Services of Kalamazoo – Kathy Lentz
- CMHCM – Lisa Martinson, Cynthia Segar





Community Living Services — Starting with people when they are new (at Initial Intake)

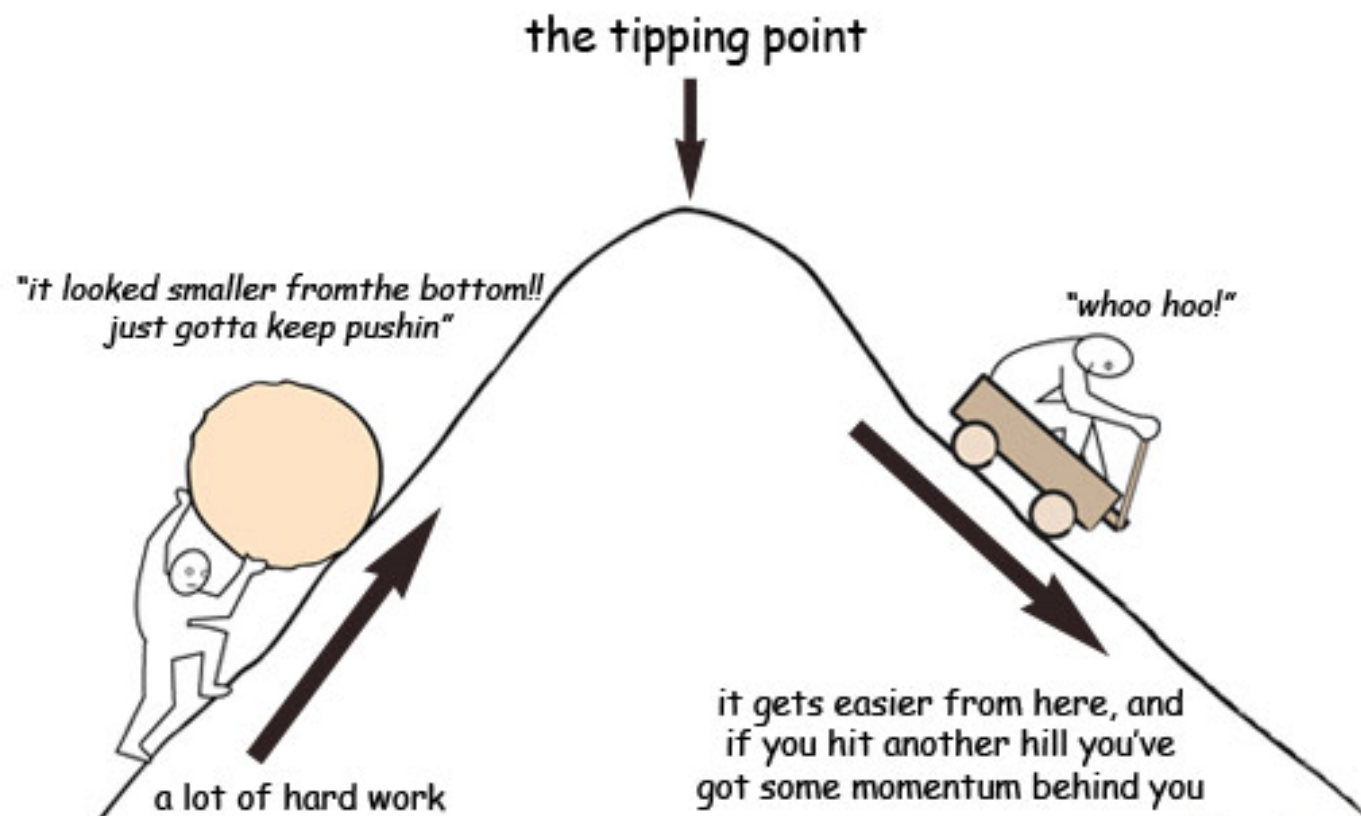
Provides services in Wayne, Oakland,
Macomb, Kent, and Ottawa Counties

Has delegated Intake functions in Wayne
and Oakland, so the tools were piloted in
these regions at the initial point of access/intake
(people new to services).




***By show of hands,
who here really likes
CHANGE?***









“Do the best you can
until you know better.
Then when you know better,
do better.”

Maya Angelou





Hesitations

- ⦿ Training on tools /implementation skills.
- ⦿ Implementation Time. Added 20 minutes of additional time to meetings when new users were implementing the tools
- ⦿ Can be perceived (especially at first) as “just one more thing to do”



Pros / Advantages



- ◎ Helps bring a bigger perspective – Assists people to identify strengths, resources, supports, opportunities beyond publicly funded services.
- ◎ Helps the person and their family be more directly invested in the planning process by demonstrating that their views matter and they are in control of determining goals that would help advance a “good life” as they define it.
- ◎ The framework helps staff have better facilitation skills, tools, and direction.



"A lot of people have gone farther than they thought they could because someone else thought they could."

~Zig Ziglar



**The goal is NOT to
have great services;
the goal is to
HAVE A GREAT LIFE!**





Integrated Services of Kalamazoo-
Returning to our Roots



From Compliance to Excellence

- ◎ The past several years (decade even), there have many external pressures
 - ★ MDHHS Site review
 - Focus on “scope, intensity, duration”
 - ★ HSW goal/objective requirements
 - Goals required in areas individuals not necessarily interested in (i.e. hygiene, toileting, bathing, dressing)
 - ★ Medicaid Claim verification
 - Does the documentation match the date/time/content of service note

*None of this measures whether a person is building the life they want
with supports as needed*



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From Compliance to Excellence

The compliance focus has disillusioned Case Managers. Other factors are also contributing to burn out:

- ⦿ COVID-19 brought new and continuing challenges in terms of safety/wellness, communication and connections, and limited community and public resources
- ⦿ Electronic Health Records are built upon regulations (compliance), less so on individuals dream of their best life.
- ⦿ The thousands of code and modifier changes in the past two fiscal years (i.e. daily CLS from 3 code/modifier options to 96 options in a single day)



Changing the Culture

Charting the Lifecourse framework and tools gave us the road map for a re-set, a re-focus on supporting to improve their lives, their best lives.

- ★ Refocus on Person-Centered Planning, not writing the Individual Plan of Service
- ★ Every Lifecourse Tool starts with the individual and places them in the center of focus.
- ★ Listen to the individual and worry about compliance later
- ★ Come back to the tools to measure progress with the individual
- ★ Developed guides and support for the code/modifier issues (not focus of Case Managers anymore)



Changing the Culture

- ⦿ Case Manager Supervisors received training from DD Council workgroup on all the tools. Introduced tools in clinical team meetings, used clinical tools with team members, used tools with individuals they support.
- ⦿ Training for all Case Managers on Charting the Lifecourse by originators—UMKC
- ⦿ More practice in clinical teams, using the tools with other team members and for themselves.
- ⦿ Accessing Independent Facilitation to assist the planning discussions



Takeaways

- ◎ Individuals are LOVING the new planning process---they love having the Trajectory, Integrated Star, Reciprocal Roles and all tools in their hands. It is a picture of who they are and what they want their lives to look like.
- ◎ Individuals want follow up (“Periodic Reviews”) on the Lifecourse tools—tracking the items more personally meaningful to them
- ◎ Lifecourse provides guidance for having conversations with individuals and their circles of support and the tools provide a shared way of documenting and coming back to those life plans.



Takeaways

- ◎ Case Managers enjoy using the framework and the tools:
 - ★ Helps them establish relationship
 - ★ Keeps focus on goals of individual, not requirements of the system/compliance
 - ★ Structures conversations that are action oriented
 - ★ Provides more person-centered information for treatment planning meeting (instead of starting with the requirements of the treatment plan)
 - ★ “Now I’m doing what I entered this field to do---help people change their lives



Takeaways

- ◎ As Case Manager Supervisors use the various tools with Case Managers during supervision, the tools come to life. They help the Case Managers personally see how the tools can support someone to change their life and build the life they want.
- ◎ Some Case Managers have used the tools for personal career planning, self-care and work-life balance planning





Community Mental Health for Central MI and Charting the Life Course

6 counties in Central MI
(Clare, Isabella, Gladwin,
Midland, Mecosta, Osceola)



CtLC at CMHCM

- ⊙ October 2018 CtLC event @ MSU
- ⊙ CMHCM strategic goal to build capacity and strengthen competencies.
- ⊙ 2019 CtLC introduction offered to internal staff, external providers and individuals served.



CtLC at CMHCM

- ◎ 2020 Management and CMHCM Board introductions
- ◎ 2021 15 Ambassadors Trained
- ◎ 2021 TA for Ambassadors
- ◎ 2021 TA for Subject Matter Expert Teams
- ◎ 2021 November 2 and 3 Charting the Life Course onsite events



Integrated Supports Star



INTEGRATED SUPPORTS STAR | PLANNING



Integrated Supports Star



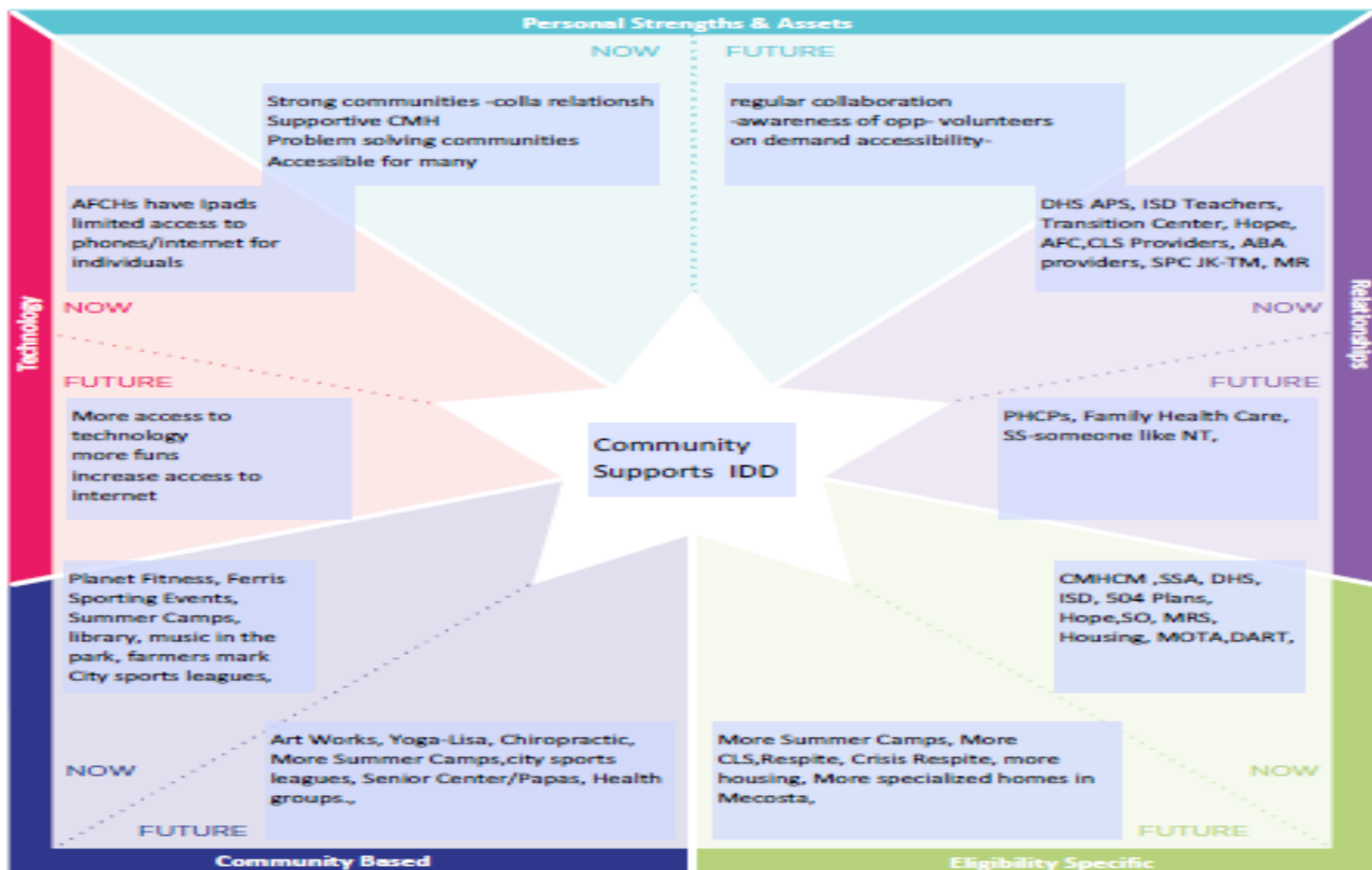
How are we using the Star

- ⦿ Format for determining current resources and needs
- ⦿ Individuals
- ⦿ BTC/HSW/UM interdepartmental interactions
- ⦿ Providers
- ⦿ Case Management Teams
- ⦿ Agency





INTEGRATED SUPPORTS STAR | PLANNING



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Design team recommendations

- ◎ Focus on Educating and connecting to Families and Self Advocates
- ◎ Be intentional about when, where and how we engage Self Advocates and families during the pilot – it is important for people to get excited about the concepts and tools, but not before they can actually effectively use them in their community
- ◎ Use Ambassadors for widespread education around the state with Schools, Self Advocates, Families, Colleagues in the system (CMH, providers, etc)
- ◎ Use Ambassadors as part of the intake process to educate individuals coming into the system during the pilot (at pilot sites)
- ◎ Train and use Peer Supports to engage with Self Advocates and Families



Phase 2

- ◎ The MI CoP team will utilize the design team feedback and lessons learned from Phase 1 to develop a pilot for Phase 2.
 - ★ Follow the same model as design team
 - ★ Peer support and training
 - ★ Inclusion of Peer Supports, Independent Facilitators
 - ★ Statewide training and education for individuals and families
- ◎ Timeline
 - ★ Start with added sites in 2022



How you can get involved

- ⦿ Looking for participants to join phase 2 of pilot
- ⦿ Looking for representation and participation from each PIHP region
- ⦿ Submit statement of interest to Tracy Vincent at Michigan Developmental Disabilities Council, vincentt1@Michigan.gov
- ⦿ Attend training future training events



More Information

- ◎ Michigan DD Council – Tracy Vincent, Tedra Jackson
- ◎ MDHHS – Laura Demuse, Price Pullins
- ◎ DDI – Angela Martin
- ◎ Pilot Design Team members
- ◎ UMKC Institute for Supporting Families

